BlueCross BlueShield of Minnesota

St. Louis County

$250 Deductible CMM Plan

Effective Date: 01/01/2012

THIS IS ONLY A SUMMARY AND IS SUBJECT TO THE TERMS OF THE CONTRACT**

Calendar Year Deductible	$250 Single $500 Family
Calendar Year Out-of-Pocket Maximum Non-covered charges and charges in excess of our allowed amount do not apply to the out-of-pocket maximum.	Medical - $750 Single $1,500 Family
Coinsurance	Deductible then 90% coinsurance.
Benefit Payment Levels	Payment for Participating Network providers as described. If non-participating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amounts.
Lifetime Maximum per Person	Unlimited.
Dependent Child Age Limit	To age 26; through the calendar month of the birthday.

COVERED CHARGES	**BENEFIT PAYMENT**
Preventive Care	
• Well Child Care through age 5 • Prenatal Care	100%
• Routine Physicals ages 6 and older • Office Visits • Cancer Screening • Routine Hearing and Vision Exams • Routine lab and x-ray services • Immunizations and Vaccinations	100%
Physician Services	
• In-Hospital Medical Visits • Surgery and Anesthesia • Inpatient Lab and X-rays, etc.	Deductible then 90% coinsurance.
• Office Visits for Illness or Injury • Urgent Care (clinic based)	Deductible then 100% 90% after deductible for all other services.
• Outpatient Lab and X-ray	Deductible then 100% coinsurance.
Other Professional Services	
• Chiropractic Care	Deductible then 100% 90% after deductible for all other services. No coverage with nonparticipating providers.
• Home Health Care	Deductible then 90% coinsurance.
• Physical Therapy • Occupational Therapy • Speech Therapy	Deductible then 100% 90% after deductible for all other services.

COVERED CHARGES	BENEFIT PAYMENT
Inpatient Hospital Services 365 days of medically necessary care in an average semi-private room.	Deductible then 90% coinsurance.
Outpatient Hospital Services	
• Diagnostic tests • Pre-admission Tests and Exams	Deductible then 90% coinsurance.
• Chemotherapy & Radiation Therapy • Physical, Occupational & Speech Therapy • Kidney Dialysis • Scheduled Outpatient Surgery • Non-emergency, illness related visits	Deductible then 90% coinsurance.
• Urgent Care (Hospital Based)	Deductible then 90% coinsurance.
Emergency Care	
• Emergency Room	100% coverage after $50 copayment
• Physician Services	Deductible then 90% coinsurance.
Ambulance *Medically necessary transport to nearest facility*	Deductible then 90% coinsurance.
Medical Supplies	Deductible then 90% coinsurance.
Behavioral Health Care (Mental Health and Chemical Dependency Care)	
• Inpatient Care	Deductible then 90% coinsurance.
• Outpatient Care	Deductible then 90% coinsurance.
• Professional Care	Deductible then 90% coinsurance.
Prescription Drugs	
Retail – 31 days supply FlexRX	$10 Generic $20 Preferred $40 Nonpreferred
90dayRx – 90 day limit *(PrimeMail and Participating Retail Pharmacies)*	$20 Generic $40 Preferred $80 Nonpreferred

**This is only an outline of plan benefits. The contract and certificate include complete details of what is and isn't covered. Services not covered include items primarily used for non-medical purposes, over-the-counter drugs/nutritional supplements, services that are complementary, experimental, not medically necessary, or covered by workers' compensation or no-fault auto insurance. We feature a large network of health care providers. Each provider is an independent contractor and is not our agent. Nonparticipating providers do not have contracts with Blue Cross and Blue Shield of Minnesota. Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association.

If you have any questions regarding plan please call Customer Service at 651-662-5001 or 1-800-531-6676.